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Biological & Medical Serials

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# Maritime Medical News

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. XVI. HALIFAX, NOVA SCOTIA, OCTOBER, 1904. No. 10

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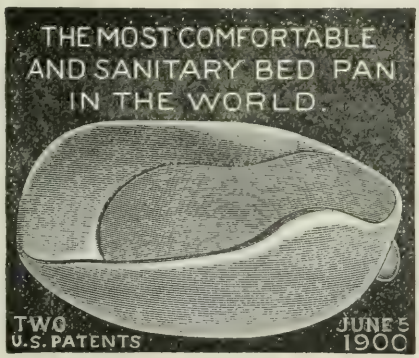


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# MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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## Presidential Address.

### MEDICAL SOCIETIES—BEGINNINGS AND DEVELOPMENT.*

By J. D. LAWSON, M. D., St. Stephen, N. B.

In the practice of Medicine, as in everything else, we find there is nothing new under the sun.

The modern travelling physician had a prototype in the habit of the Greek Asclepiades, who traversed the land practising his profession here or there; and those of us of more staid habits, resemble others of that order who settled in one place when they found the conditions favorable for a lifework

But the Asclepiades always remained in touch and gathered together at stated intervals to attest their adherence to their principles at their sacrifices and religious festivals. This is known from an inscription found in the ruins of the temple of Asclepias at Athens, which dates back to the third century before Christ.

This habit of ours of meeting together is not a feature of modern life but is instinct in the human family. Man is a social animal, and when a number are united by common interests, it is natural to band themselves together for mutual assistance and fellowship. It is to this feeling of a common bond we owe the formation of societies, guilds, or fraternal unions—and this instinct is one of the factors in civilization.

In ancient times the caste spirit prevailed and the son usually followed the calling of the father, as is the case in certain eastern countries today. In this way the knowledge and capacity of the parent becomes a precious legacy to the son. This is the tradition of the sons of Asclepias in whose family the healing art was handed down.

*Presidential Address, delivered at meeting of New Brunswick Medical Society, July 19, 1904

When the medical renown of Asclepias preserved by legend and increased by the achievements of his posterity, which after centuries procured his deification, it is possible that other physicians, not of his kin, asserted relationship to produce the impression that *they also* possessed the medical secrets of the Asclepiades. These latter physicians did not limit their pupils to those of their own race but received others as well.

In the tribal stage of the development of man brotherhood was created ceremonially, by mingling a few drops of blood of two persons in a cup of wine and drinking it. Each received into his veins a portion of the other's blood and thus they became blood-related, and were bound by the same mutual obligations as they would have been had the same mother given them birth.

I do not know that this particular ceremony was performed amongst the Asclepiades, but some ceremony must have been gone through, as any one received into the fraternity was constrained to swear an oath that he would honor his teacher in medicine as father, and regard his children as his own brethren.

Around the temples consecrated to the God of Healing, physicians established themselves and formed societies. The members called themselves Asclepiades, declared that they were the descendants of Asclepias, and to them had been communicated the fund of pure and undefiled medical learning. Later the term Asclepiades became more comprehensive and finally was applied to the whole body of medical men. This fiction of a common extraction from Asclepias and the pedigree of his alleged descendants continued and was an act of piety demanded by the people, on account of which they gave the physicians their full confidence.

The oldest societies of Asclepiades were at Rhodes, Croton, Cyrene, Cos, and Cnidos. There they found opportunity in their intercourse with the priests devoted to the cult of Asclepias and to the patients who there sought cure, to learn the methods of treating various diseases, and to collect a fund of medical observation and experience.

Between the healing art as practised in the temples and that of the Asclepiades the great difference was that the practice of the priests claimed to be the result of divine revelation and that of the Asclepiades was the fruit of human wisdom.

The societies of the Asclepiades were distinguished by their scientific principles. The local conditions, the character of the predominating diseases, the tendency of their theoretical explanation, the intellectual standing of the individuals who were then active, and their relations with philosophical, mathematical, or physical investigations or systems, gave rise to *various* medical sects which rivalled one another in their love of science and mankind.

With the Greeks, the pursuit of science and knowledge in all its forms received the countenance of the highest in the land, but it was

not so amongst the Romans. With the Roman nobility nothing was worthy of consideration except politics and war. On that account the pursuit of medicine was left to those of humble birth, and many physicians were slaves. In addition there were many foreign adventurers from Greece and the East, and these took care that their medical knowledge and skill was well advertised. From this unfortunate condition, it is no wonder that medicine, even at its best, showed little or no original development, but relied almost entirely on the Greeks.

Distinctions prevailing amongst the Roman physicians, with respect to social position, education and professional knowledge, prevented the development of the spirit of fraternity. The ablest of the profession held aloof and there was no friendship between the various medical castes. Consequently there were few, if any, societies and fraternities amongst the physicians, altho' "collegia" were formed everywhere amongst the artisans and merchants. Only two inscriptions have been found which give any hint of the formation of a guild or brotherhood. One, the epitaph of a deceased "*brother*" practitioner. The other dating back to 153 A. D., announces the primitive formation of the Collegia Æsculapius et Hygeiæ.

Whether or not the institution of guilds was *begun* with the Romans, it is certain that very early in the medieval ages, societies of that kind existed. On account of the weakness of the governments this was necessary for their own protection, and guilds filled an important part of the social and political life of that time. In accordance with the religious ideas of the time, these various guilds flourished under the patronage of some Saint. The physicians chose a pair of brothers, Cosmas and Damian, who had practised under Diocletian, and had suffered martyrdom for their Christian faith. In common with other guilds, the societies of physicians were simply for the purpose of preserving their rights against the authorities and the public, and for aiding their brethren and followers. But other matters developed, foremost amongst these being the supervision and directing of medical instruction.

The oldest high schools and academies of Europe, especially those of Salernum and Montpellier, were a direct out-growth of the *medical* guild.

We may feel assured that individual masters in medicine *first* taught there, and later united in a common cause. Thus medical schools originated, and to these other faculties were successively added.

In Paris, as early as the beginning of the thirteenth century, the physicians as well as the masters of the other arts combined into organized societies with self-imposed statutes and laws. The medical guild was incorporated with the university as its medical faculty, and the conditions were similar in most of the academies which were founded later.

The *members* of the medical guild were likewise connected with the university, even if not serving in the capacity of instructors. In their gatherings they occupied themselves with not only the concerns of their practice, but with the requirements of medical education and administered medical examinations.

In process of time the guilds as corporate bodies outlived their usefulness, and ceased to wield the power they had. In the change, the influence which the guild had possessed over medical instruction and examination was lost. The trend of the times demanded more freedom and independence of the individual, it condemned the might of castes and created free associations of those who, animated by one purpose, sought their highest reward in the common culture of the art or science which they served.

The surgeon was a matter of evolution with which I will not detain you, but the division between internal and external medicine was not supported in antiquity by law but by tradition, and until the middle ages the surgeon was the equal in learning and training of those who treated internal diseases, and occupied the same position in social life. This continued until the time when the clergy were forbidden to practice surgery by their church superiors, and the value of all practical occupations sank under the influence of the scholastic habit of thought. At that time the clergy occupied the foremost place amongst the various classes, and when they turned away from surgery it was looked upon as not compatable with education and standing. Gradually those who were attracted to surgery by natural gift, and those who were denied reception into the medical guild on social or religious grounds, developed a special class or caste, and as early as the 13th century formed an organized corporation distinct from the guild of physicians.

From this despised body has come, by leaps and bounds during the last thirty years, what I heard only a few days ago called the most important part of scientific medicine.

Verily, "the stone which the builders rejected is become the head of the corner." In London, in 1461, the old fraternity of surgeons and barbers became the "Surgeons' Guild," from which, in 1745, the barbers were excluded and became the "Company of Surgeons." In 1800 they desired a Royal Charter, which, after much opposition, was granted, and they became the R. C. S. They thus skilfully accomplished the transformation from Guild to Association, and retained their influence upon medical education, as they have still the right to conduct examinations and give authority to practise. A number of similar associations were created in other large cities in the British Empire which have the right to give license to practise, but generally, in Europe, on the disappearance of the guild, the medical societies lost the direct control of medical instruction.

As an example of small beginnings and fortunate developments let us look at the British Medical Association. This association dates its beginning from 1831, when, in response to the invitation of Dr. Chas. Hastings, of Worcester, fifty to sixty medical men, all from the provincial towns and cities in the south of England, assembled in Worcester and formed a Provincial Medical and Surgical Association, to meet annually in some of the provincial towns for medical intercourse, support and professional improvement. The membership at the end of the first year numbered only one hundred and forty. Under the guidance of its founder, Dr. (afterwards Sir) Charles Hastings, its membership annually increased and its annual meetings extended to centres further north, meeting in York in 1741. It was not until 1856 (twenty-four years after its organization) that it began to claim national attributes, by changing its name to British Medical Association, and it did not hold its first meeting in the metropolitan City of London until 1862.

It now embraces branch associations in every section of the British Empire. We have one here in St. John and one in Halifax. The annual convention is held in a different city, continuing for a week, discussing scientific questions and professional interests. It has crossed the Atlantic and honored Canada by holding its meeting in our midst.

On this continent there are many very old medical societies. In 1763 eleven physicians petitioned the General Assembly of the Colony of Connecticut They continued their organization and are perpetuated in the New London County Medical Association. This was in 1763—before any army surgeons could form the nucleus of an organization and long before the Colony became a State, yet three of their number lived to see the Connecticut Medical Society incorporated and take part in its deliberations. The memorial is unique. In part it says: "Whereas more than one hundred years have already passed since the planting of this colony, and nothing has been publicly done to distinguish between the honest and ingenious physician, and the quack or empirical pretender, by reason of which imposture and imposition has been and is but too commonly practised among us to the great injury of the people as well as the disparagement of the profession." The chief request of the petition is to "annually choose a committee for the time being to have full power to examine, and if found duly qualified, approve such candidates for the practice of physic who shall offer themselves for examination."

At that time (1763) there was not an incorporated medical society, nor an organized medical school, nor any authority to confer a medical degree, and the step was far in advance of its time. The only medical colleges about that time were the University of Pennsylvania, founded in 1765; Kings College, now Columbia, 1768; Harvard, 1782.

There was the usual opposition. One of the arguments was that "the main purpose of it was to increase the pecuniary emolument of the faculty; besides, it was not customary to make laws for the benefit of particular classes." There was apprehension that danger might come from special privileges and monopoly. The charter was granted in 1792. The resolution by which it was introduced reads: "Whereas well regulated medical societies have been found to contribute to the diffusion of true science, and particularly the knowledge of the healing art; therefore, be it enacted that there be a medical society formed within this State."

This will give you some idea of the conditions surrounding the practitioners of medicine in the early life on this continent, and of the difficulties met with and opposition to be overcome in the formation of a national or state society with power to direct and control medical education and practice. With regard to the special pains of parturition felt at the birth of the New Brunswick Medical Society, I shall say nothing, as that would be a theme more fitting for the 25th than the 24th annual meeting. This I shall say, we, as a society, must thank the originators and framers of the law—in that we are highly privileged above many others in having the appointing of the major portion of the committee in whose hands is the regulating of the practice of medicine in our province. This is a greater privilege than the average physician realizes. That *this is* appreciated at least in some degree is seen in the fact that the triennial meeting, at which elections are held, brings a slight increase in numbers over the other years. But is there no way to interest the members the province over and induce them to make an extra effort to attend every year? We must realize that a member in the remote part of the province has a right to know what is being done, but if compelled by causes beyond his control to be absent all he ever sees is the mere skeleton of a newspaper report or the outlines in the MARITIME MEDICAL NEWS. This tells him only what is done and past. Each year the registrar of the council reads to the society his report of the past year. Would it not be possible for the council to close their year earlier and arrange that the registrar's report to be presented to the society be forwarded to each registered practitioner sometime a month—a week—previous to our annual meeting? Speaking for myself, I have heard a number of these reports read, and I can honestly say I did not—could not—take in and appreciate what was in the report; but if that report had been before my eyes and time given to think of it, the subject matter could be understandingly discussed. I am convinced that some such plan would increase the interest in the proceedings of the society. An example of what I mean is this: How many of the rank and file of our society, outside of the City of St. John and environs understand the principle behind the unpleasantness which caused a graduate of Edinburgh University to move

from St. John after having located there ? I venture to suggest that the numberis small, and I am sure that the number is smaller who know that we on the border have a similar case, but the conditions surrounding it prevent us from moving in the matter. I think if the report of the council containing these items had been in the hands of the members a short time before the meeting, we would not complain of the paucity of members. As an attraction, nothing will take the place of the glad hand and the living voice such as we always receive and hear at these meetings.

Another of the developments about which I can say nothing new is Reciprocity in Dominion Registration. Personally, I can only emphasize this desirability and urge the continuation of the agitation until the length and breadth of our country, if not the British Empire, may be the field for the well prepared graduate and registered practitioner.

It is with sorrow I speak of the death during the past year of young Dr. Shaughnessy.

Dr. Shaughnessy was a native of the town of St. Stephen, and was a bright, clever young man. Many of us can look back to the time when he read a paper before the New Brunswick Medical Society. What enthusiasm he showed ! And I think—nay I am sure--that that bright optimism he carried throughout his work would, had he been spared, have raised him high in his chosen work. All too soon was he cut down with that dread disease—the White Plague.

The Medical Societies are a means of promoting social intercourse and friendly relations amongst members, and of forwarding the progress of medical science. By some they are looked on as a form of post-graduate course. More especially is this felt by those who prepare papers, report cases and take part in the discussions. The mental and literary training and discipline acquired in this manner are of the highest value to us. Therefore there is every reason, so far as self improvement goes, for each of us to take some active part in these meeting.

We, the New Brunswick Medical Society, hold the honourable position of controlling and regulating the practice of medicine in our Province, and of being an association which "as a social and professional reunion of kindred spirits and great minds its memories afford perennial delight. It has given impetus to the progress of medical polity and science ; it has brought together a bright constellation of intellect and cemented the bonds of friendship among good men and true, and is a concrete example of the each for all and all for each."

## Original Communications.

### THE SURGICAL TREATMENT OF COMPLETE DESCENT OF THE UTERUS.*

By E. C. Dudley, M. D., Chicago.

Complete descent of the uterus, descent to the third degree, which may be defined as that deviation in which a part or the whole of the uterus is outside of the vulva, is always associated with extensive injury to the pelvic fascia, the pelvic connective tissue, the muscles of the vaginal outlet, the perineum and the vaginal walls; in fact, these injuries of the pelvic floor constitute the essential lesion, the mal-location of the uterus being an incidential factor.

The uterus in its normal position lies across the pelvis, the fundus pointing in a slight upward anterior direction, and the external os in a slightly downward posterior direction. The long axis of the uterus in its normal direction makes an acute angle with the long axis of the vagina, which extends from the vulva upwards and backwards in the direction of the hollow of the sacrum. Generally speaking, mobile anteversion with some degree of anteflexion is the normal position of the uterus; at any rate, the uterus in its normal range of movements does not deviate, unless temporarily, beyond the limits of a certain normal anteversion and anteflexion.

In the etiology and treatment of descent the practical significance of this acute angle between the axis of the uterus and vagina is very great, because the uterus in the act of prolapse must descend through the vaginal canal in the direction of that canal, that is, a coincidence of the two axes is a prerequisite of descent. Now, if the essential condition of descent is a coincidence of the axes, it follows that one factor, at least, in the treatment of descent must be to restore the normal angle between the axes.

In labor the anterior wall of the vagina is depressed, stretched and shortened by the advancing child that during and after the second stage the anterior lip of the cervix uteri may be seen behind the urethra. The location of the cervix—so close to the anterior wall of the pelvis—necessarily involves great stretching of the utero-sacral supports which normally hold the cervix uteri, and together with it the upper extremity of the vagina close to the hollow of the sacrum. The function of the post-uterine ligaments having been temporily impaired, the upper extremity of the vagina is displaced forward, so that the

*Read before meeting of Canadian Medical Association, Vancouver, B. C., August, 1904.

uterus, having sufficient space between itself and the sacrum, instead of maintaining its normal anterior position, may fall backwards into retroversion and thereby bring its own axis into line with the direction of the vagina. Frequently the change in the direction of vagina from the normal oblique to the abnormal vertical is still further increased by injury to the vaginal outlet; the perineum may be torn in any direction, and what is more serious, it may be torn away from its pubic attachments and in this way may be displaced backwards towards the tip of the coccyx; in fact, such displacement is so common as the result of injuries to the perineum, as to suggest the propriety of a change in terminology from laceration to displacement of the perineum. The upper extremity of the vagina being displaced forward and the lower extremity backwards, and the direction of the over stretched, dilated vagina now being vertical, the heavy uterus, having its long axis in the same vertical direction, has all the conditions favorable to progressive descent.

If the puerperium progress favorably with prompt involution of the pelvic organs, and if the relaxed vesico-vaginal wall and other parts of the pelvic floor, especially the utero-sacral supports and the broad and round ligaments, recover their normal tone, then the whole pelvic floor, including the uterus, resumes its normal relations. But if the enlarged heavy uterus remain in the long axis of vagina, and especially if the fundus uteri be incarcerated under the promontory of the sacrum, with the sacral supports stretched so much and for so long a time that they cannot recover their contractile power; and if normal involution of the pelvic organs be arrested, then descent may not only persist, but may progress with constantly increasing cystocele and rectocele until the entire uterus has extruded through the vulva.

It is most important to remember that complete prolapse of the uterus is only an incident to prolapse of the pelvic floor. The whole mechanism is that of hernia, and the condition is hernia, for the extruded hernial mass drags after it a peritoneal sac which, hernia-like, contains small intestines. This sac forces its way to the pelvic outlet and extrudes through the vulva, having the inverted vagina for a covering.

The prolapsing uterus may be related to the vaginal walls in either one of two ways: the prolapsing vaginal walls may drag the uterus down after it, or the uterus itself may descend along the vaginal canal by force of its own weight and drag with it the reduplicated vaginal walls. Extreme prolapse of the uterus, the organ being covered thus by reflected vaginal walls, has given rise to considerable confusion in pathology, and by many standard authors wrongly has been called hypertrophic elongation of the cervix uteri. In a given case, the possibility of infra-vaginal elongation may be settled easily

by placing the patient in the knee-breast position, when the uterus of its own weight will fall toward the diaphragm and the reduplicated vaginal walls will unfold and utero-vaginal attachments will appear in the normal place instead of being, as it seemed to be, high up on walls of the uterus. Those cases in which reduplication of the vaginal walls does not almost entirely explain apparent great elongation of the cervix, are rare exceptions. When formerly these mechanical conditions were attributed to hypertrophic enlargement of the uterus itself, and were regarded as adequate indications for the removal of the cervix, the surgeon, in the attempt to remove what he supposed was the elongated cervix uteri, sometimes invaded the bladder anteriorly and the rectus posteriorly.

*Surgical Treatment.*—In passing, it may be well to mention, for the purpose of condemning it, an operation perhaps more frequently performed than any other for the cure of complete descent, namely, the operation which generally passes under the name of Stoltz. This operation is designed to narrow the vagina, and thus to maintain the uterus somewhere in the pelvis above the constriction. Operations of this class usually consist of the removal of an elliptical piece from the anterior or posterior vaginal wall, or from both, and of closing the exposed surfaces by means of purse string suture. No effort is made to restore the normal axes of the uterus and vagina. The whole purpose is to make the vagina so narrow that the uterus cannot pass through it. Such operations generally fail, because they leave the uterus and vagina in the same axis, and because the restricted vagina cannot resist the downward force of the uterus, which almost invariably dilates the vagina a second time and forces its way through with reproduction of the hernia. Moreover, the operation always does permanent harm, because it shortens the vagina, thereby making it draw the cervix away from the sacrum towards the pubes, so that the body of the uterus may have room to fall backward to the position of incurable retroversion. We may, without discussion, perhaps throw out all operations belonging to the Stoltz group. The same may be said of all plastic operations in which the vaginal surfaces are exposed by superficial denudation and brought together by sutures.

After a prolonged trial of the principal surgical procedures which have been made use of for the cure of complete descent, I am prepared to lay down certain essential principles, as follows: An efficient operation on the vaginal walls should have for its object, not narrowing the vagina, but restoring the normal direction of it with a double purpose, so that (*a*) the upper extremity, together with the cervix uteri, shall be in its normal location within an inch of the second and third sacral vertebrae, just where the utero-sacral ligaments would hold it if their normal tonicity and integrity could be restored, and

so that (*b*) the lower extremity of the vagina shall be brought forward against the pubes. The fulfilment of these two indications will restore the normal obliquity of the vagina, and will hold the cervix uteri so far back toward the sacrum that the corpus uteri must be directed forward in its normal anterior position of mobile equilibrium. With these conditions, the uterus being at an acute angle with the vagina and having little space posteriorly, cannot retrovert and turn the necessary corner which would permit it to prolapse in the direction of the vaginal outlet. In order to accomplish this, two things usually are necessary :

### 1. Excision of the Cystocele.

*Anterior Colporrhaphy.*—The plastic operations performed on the anterior and lateral walls of the vagina by Sims, Emmett, myself and others, which have consisted of superficial denudation and reefing of the anterior or lateral walls of the vagina, have been only partially successful, first, because they did not adequately force the cervix uteri into the hollow of the sacrum; second, because efficiency requires deeper work than superficial denudation can accomplish, and third, because these operations did not utilize the broad ligaments sufficiently for support.

The above principles, emphasized by Reynolds in a recent paper, have led me to modify my own operation materially. Complete prolapse, being hernia, should be treated according to the established principles of herniotomy by reducing it and then excising the sac in such a way as to expose strong fascial edges, which should be firmly united by sutures. The absurdity of treating any other hernia by superficial denudation and reefing or tucking in the surfaces by sewing them together must be apparent to any one. In order to indicate the part which the broad ligaments must have in a correct operation, it is only necessary to observe the fact that vaginal hysterectomy commonly results in holding up the pelvic floor and with it the rectum, vagina and bladder, because in this operation the broad ligaments are usually fixed to the vaginal wound. But why should not the same result be aimed at by similar means, even though the uterus is not removed ? The operation which I would urge is performed as follows:

*First Step.*—To split the antero-vaginal wall—that is, the vaginal plate of the vesico-vaginal septum—by means of scissors, from the cervix uteri to the neck of the bladder, then to strip off the vaginal from the vesical layer of the vesico-vaginal wall and cut away the redundant part of the vaginal plate.

*Second Step.*—The redundant part of the vaginal wall having been removed, to extend the incisions and remove the mucous and submucous structures, to either side of the uterus, being sure to reach

the fascial structures, which are in direct connection with the lower margins of the broad liagments, or, what is better, to reach the ligaments themselves.

*Third Step.*—To introduce silk worm gut or chromic catgut sutures so that when tied they will draw the loose vaginal tissues and the broad ligament structures on either side of the cervix uteri in front of the cervix so as to force the cervix back into the hollow of the sacrum.

*Fourth Step.*—The sutures introduced in the third step having been tied, additional interrupted sutures are introduced to unite the vaginal wound from side to side; this suturing is continued to a point near the urethra, when most of the redundant vaginal wall will have been taken up; there will usually remain, however, the lower portion of the cystocele and perhaps some urethrocele, which cannot be disposed of by bringing the margins of the wound from side to side, but can be taken up by uniting the remaining part of the wound in a transverse direction.

Even at the risk of prolixity I repeat that it is essential to remove the entire thickness of the vaginal layer of the vesicovaginal septum.

*Contraindications to Elytrorrhapy.*—Elytrorrhaphy is usually unnecessary, and therefore contraindicated in descent of the first degree. The special province of the operation is in complete prolapse or procidentia when associated with cystocele. The operation further is contraindicated by tumors and adhesions which render replacement and retention impossible and in diseases of the uterus or its appendages, which demand their removal. When such contraindications do not exist, elytrorrhapy and perineorrhapy in a majority of cases are quite as effective, and therefore to be preferred to the more dangerous and mutilating operation of hysterectomy.

### 2. Perineorrhaphy and Posterior Colporrhaphy.

As already stated, it is most important to appreciate the fact that in nearly every case of procidentia the lower extremity of the vagina is displaced backward. This is consequent upon subinvolution of the pelvic floor, and especially upon subinvolution or rupture of the perineum or of some other portion of the vaginal outlet. Unless, therefore, the posterior wall of the vagina and the perineum can be brought forward to their normal location under the pubes, so as to give support to the anterior vaginal wall, the latter will fall again, will drag the uterus after it, and the hernial protrusion (cystocele and prolapse) will be reproduced. The treatment, therefore, of procidentia must always include an adequate operation on the perineum or, more comprehensively speaking, upon the posterior wall of the

vaginal outlet. The operation must be performed so that it will carry the lower extremity of the vagina forward to the normal location close under the pubes; then, if the anterior colporrhaphy has been adequate. and has carried the upper extremity backward, the whole vagina will have its normal oblique direction, and its long axis will make the necessary acute angle to the long axis of the uterus.

*Hysterectomy*, if indicated should be performed by the vaginal route. As an operation for procidentia, hysterectomy is open to the following comments: Procidentia, as already shown, is hernial descent, not merely of the uterus, but also of vagina, bladder and rectum. Complete prolapse often occurs after the menopause, when the uterus has become an insignificant rudimentary organ, and therefore may be removed easily. Cases are numerous in which, after vaginal hysterectomy, the pelvic floor, and with it the vaginal walls, have protruded again through the vulva—a result which may be expected unless the operation has included anchorage of the upper end of the vagina to its normal location by stitching the severed ends of the broad ligaments into the wound made by removal of the uterus. The indications for perineorrhaphy as a supplement to hysterectomy are the same as after anterior elytrorrhaphy.

As laid down in the foregoing paragraphs, the utilization of the broad ligaments is the essential factor in the treatment of complete procidentia. The operation of elytrorrhaphy, above described, unfortunately either may fail to bring the lower edges of the broad ligaments sufficiently in front of the uterus to enable them to hold up the uterus and vagina, or the ligaments having been stitched in front, the stitches may not hold. Consequently, in complete procidentia, elytrorrhaphy, even though well performed, may fail; at least, this has been my experience in a number of cases. Therefore, the complete prolapsed uterus may have to be removed in order to secure the entire outer ends of the broad ligaments to the upper part of the vagina, and thereby give absolute support. As before stated, the operation should include the treatment of the hernial factor in the lesion, that is, removal of the redundant portion of the anterior vaginal wall. Generally speaking, the indications are somewhat as follows;

1. Extreme cystocele, not associated with the most extreme procidentia, should be treated by anterior colporrhaphy and perineorrhaphy.

2. Cystocele associated with complete procidentia properly, may be treated by hysterectony, anterior colporrhaphy and perineorrhaphy. Anterior colporrhaphy in all cases.

3. Conditions intermediate between the two conditions indicated above, and cases of very feeble or aged women, will call for special

judgment whether hysterectomy be omitted or performed. It is, however, a fortunate fact that the completely prolapsed uterus, even in aged women, is removed usually with ease and safety.

*Other Operations of Questionable Value*.—Other operations, designed to decrease the weight of the uterus by removal of it, are of questionable value. Amputation of the cervix to lighten the weight of the uterus has been practised much for the spurious hypertrophic elongation already described. Since this condition is rare, if not indeed unknown, it follows that it seldom will furnish an indication for amputation of the cervix uteri.

Alexander's operation and abdominal hysterorrhaphy belong to the surgical treatment of retroversion and retroflexion, not of procidentia. The object of these operations is to suspend the uterus from above. Hysterorrhaphy, which perhaps fulfils this indication better than shortening the round ligaments, may be indicated in cases of extreme relaxation of the uterine supports and greatly increased weight of the uterus. The results of it in complete procidentia, however, usually will not be permanent unless it is supplemented by adequate surgery to the vagina.

# PELVIC HÆMORRHAGES.*

By Murdoch Chisholm, M. D., L. R. C. P., Halifax, Nova Scotia.

Custom is inexorable. Were it not so I would gladly shirk the duty which now devolves upon me. I do not know how it has been with my predecessors, but like many a preacher I have found it harder to select a text than to prepare a sermon. Many subjects passed before my mind as suitable for an occasion of this kind. Finally I selected one which the eccentricities of medical practice has thrown into my way to an unusual extent.

Within the last few years I have had twelve cases of pelvic hæmorrhage, and I thought it well to give the society the results of my experience rather than an academic address upon professional matters in general.

Before proceeding further, I want to thank the society for the honour of placing me in its chair, a chair so ably filled and honoured by my predecessors. I have also to thank the society for placing me in that chair when its responsibilities shall end with the close of this address.

If in this place I may be allowed a word of retrospection, I must refer to the losses which we have sustained since last we last met in Antigonish.

Only one year before then we had to mourn the decease of William Muir, whose personal qualities, professional ability, and devoted interest to our society, endeared him to every one of its members. Now we have to mourn the loss of his brother David, who though seldom seen at our meetings, yet managed to shed lustre upon the profession in other spheres of life.

Death at all times is pathetic, especially so when it takes away those who have no more than buckled on their armour. Our hopes were nipped and our hearts made sad by the early death of Dr. Cameron, of St. Peters, who died at Westville, where, through his many attainments of head and heart, a promising career was opening out before him. The death of Mr. Hardy in the wilds of Labrador is especially tragic. Taken with phthisis in his fourth year at college, he was advised to leave and seek restoration to health in out door life. He went to Labrador where he heard the cry of kindred sorrowing over the unburied remains of the illfated American, Mr Hubbard, and he sacrificed his life in travelling hundreds of miles to bring Mr. Hubbard's body home to assuage but a little the grief of mourning friends.

*Read before the Maritime Medical Association, Halifax, July 6th, 1904. (Being the Address of the President of the Medical Society of Nova Scotia.)

Dr. Howard Densmore, of Elmsdale, was taken from us in the prime of life. I little thought when I parted with him here on his way to London, to further qualify himself in that great centre of medical learning, that the parting was final. Dr. F. S. Maude, of Maitland, and Dr. Dakin, of Pugwash, have gone over to the great majority.

It seems to me that medical men are apt to think all men mortal except themselves, and that these annual visitations of the grim reaper should also teach us to so number our days that we may apply our hearts unto wisdom. No other class of men are so much exposed to hardship and sickness, and none so brave and reckless in the face of all sorts of danger.

Coming back to the subject of my address, I wish to say at the outset that pelvic hæmorrhage, like ascites and jaundice, is only a symptom. It is the symptom above all others which confronts us in ectopic gestation, the one by which we are first led to make a diagnosis, which appals us by its fatal possibilities and determines the necessity of active operative interference.

The title pelvic hæmorrhage is new as far as I know, but as it embraces all the conditions incident to ectopic and other pelvic hæmorrhage I prefer it to any other now in use. Dr. Cullingworth, for instance, in his Bradshaw lecture 1902, treats of this subject under the heading Intraperitoneal Hæmorrhage incident to Ectopic Gestation. In three of my cases the hæmorrhage was into the broad ligament and therefore extraperitoneal, shewing that Dr. Cullingworth's title is faulty in being too narrow or limited. Another faulty title which is not as much used now as formerly is pelvic hæmatocele. Properly speaking this term is only applicable to blood walled off from the peritoneal cavity, a condition which comes on later as a result of inflammatory action in pelvic hæmorrhage. Extravasations of blood into the broad ligament from rupture of an ectopic sac or any other cause are correctly designated hæmatomas, but these also come well under the heading of pelvic hæmorrhage, so also do hæmorrhage into the foetal sac from its walls or from its neighbourhood, whether these find their way into the abdominal cavity through the tube or into the vagina through tube and uterus.

History and course of pelvic hæmorrhage. A woman in her usual health misses a period and goes for a few weeks usually (two or six or eight) beyond her turn to be unwell. She is seized with sudden and severe pain in the lower part of the abdomen accompanied with fainting and slight flow of blood from vagina. This faintness varies from mere weakness to sudden collapse according to the amount of blood lost. One of my patients was taken sick walking in the park and managed to walk home, a distance of three miles. Another in church walked home, a distance of half a mile. Another on the street had to be carried home. Another in the water closet barely managed to crawl to bed. The subsequent course varies with the amount of

hæmorrhage. If excessive there will be pallor of the countenance, restlessness, tossing from side to side, sighing respiration, coldness of extremities, tenderness of the abdomen, a pulse rapid and wanting in volume. Examination will usually reveal nothing definite beyond possibly a vaginal discharge of blood and a sense of abnormal fulness due to the liquid blood in the pelvis. It takes a practised hand to even detect this much and the diagnosis must rest upon the history and general condition.

Should, however, the quantity of blood lost be small or should the rupture be in the broad ligament, a different picture will be presented. The signs of hæmorrhage are less marked and soon pass away. Severe pain will be complained of in the iliac fossæ, the lower part of the abdomen will be tender, the temperature will soon rise and the pulse rate will be increased. Unless the hæmorrhage be into the broad ligament nothing definite is revealed on vaginal examination for several days. Often times the blood coagulates, inflammatory changes supervene and thickening or a well marked tumour can be made out. After several weeks a ring of cartilaginous hardness will be felt. In one of my cases, the first in which I felt it, this hardness was quite puzzling. It seemed as if a maldeveloped fœtal head were embedded in the cul de sac, and that the edge of one of the parietal bones presented. In a second case at the hospital this feature alone enabled me to diagnose a pelvic hæmorrhage of two months duration. She had been treated outside and curretted for a constant discharge of blood from the vagina, to no effect. The history taken by a fourth year student gave no clue to the cause of the condition. On detecting the cartilaginous hardness in the cul de sac, I at once diagnosed ectopic gestation and elicited the history typical of that condition which the student had overlooked.

Exacerbations of pelvic hæmorrhage. Pelvic hæmorrhage is subject to exacerbation. In one case which I saw in consultation with Dr. Sponagle there were many repetitions of hæmorrhage, each one followed by increased pain, fever and abdominal tenderness, which in course of a week or more subsided, giving hopes of resolution and convalescence without operative interference. Frequently I think this does happen, the true condition remaining undiagnosed throughout. Sometimes, however, the curative efforts of nature are nipped by infection of the hæmatoma or hæmatocele. Sometimes, alas, a freer hæmorrhage than those before determine the death of a patient already weakened by long confinement and loss of blood.

Pathology of pelvic hæmorrhage. As already indicated the most common cause of pelvic hæmorrhage is a freak of nature by which a fertilized ovum develops outside of the uterine cavity. This may be in any part of the Fallopian tube or even in the ovary. Primary development of an ovum in the abdominal cavity has not been proven. Webster thinks that development in the tubes is only possible when

nature fails in properly differentiating the mucous membrane of the tubes from that of the uterus, thus leaving that of the former capable of decidual reaction as well as the latter. If this be true then certainly, as there is no Mullerian tissue in the abdominal peritoneum, we can have no abdominal development. As soon as a fertilized ovule begins to develop in the Fallopian tube the mucous membrane becomes congested. The vessels around the ovule become dilated, their walls are thinned or perforated and therefore hæmorrhages into the tube are frequent before its walls give way. The blood which thus flows into the tube escapes at both ends. It escapes into the vagina through the uterus and into the abdomen through the fimbriated extremity. That into the vagina is dark, small in amount and persistent. This is important for diagnosis, as the hæmorrhages in abortion are red, excessive and of short duration. Very often patients and doctors are deceived by not noting these differences. The resemblance to abortion is increased by the onset of pain, a pain which differs from that of abortion by being more continuous. Now all the authorities say that the pain is caused by either rupture or tubal efforts to expel the ovum. I hold that the pain in first caused by the sudden distension of the tube consequent upon the sudden giving way of one or more vessels, and secondly by inflammatory reaction in the peritoneum caused by the presence of blood acting as a foreign body. The specimen I shew you I think proves this. Here the tube was never ruptured. It is in fact fairly thick over the sac or mole,—yet when I opened the peritoneum, dark blood welled out of the peritoneal cavity and a mass of blood clots filled the pelvis. The sack itself is transformed into a mole, and the increase of size consequent upon this, as well as the distending force of the blood around it acting upon the tube walls must inevitably cause considerable pain. In another of my cases on opening the abdomen there was no blood to be seen. The right tube was much distended. Its fimbriated extremity dipped down and was attached tot he pelvic floor and surrounded by well adherent hard coagulated blood. On freeing this end there was alarming hæmorrhage, which was controlled by nipping the broad ligament. Here the orifice of the tube was effectually plugged, its outlet must have been partially plugged and the consequent distensions must have caused the pain of which the patient complained.

Mr. Noble relates a case in which the blood clots found in the pelvis were coiled up much as though they had been ground through a sausage machine; the blood clotted in the tube and the clot was then forced out as a sausage shaped mass by the continuance of the bleeding—in other words the vis a tergo.

The location of the developing ovule influences the course and symptoms. When the ovule is located near the uterus in the isthmus, which is the narrowest and most unyielding part of the tube, we are apt to meet with an early and alarming if not fatal hæmorrhage. My

first case, 15 years ago, was of this character. It proved fatal on the second day after the hæmorrhage, and on postmortem the tube was found ruptured in its inner third. The condition was diagnosed correctly but we did not have the courage to open the abdomen. A valuable life was sacrificed on the reeking altar of professional incompetence. We did not know as much then as we do now, and fifteen years hence we may wonder at our present ignorance.

When the ovum develops in the ampulla of the tube, as in the specimen submitted to you, instead of fatal rupture we are more apt to have a small hæmorrhage of a persistent character into the vagina and abdomen, with the formation of a hæmatocele and its concomitant symptoms.

Again when the ovum develops in the outward end of the tube we are apt to have an early slight hæmorrhage soon followed by tubal abortion and fatal hæmorrhage. The gaping vessels in the uterus are quickly closed after the ovum comes away. It is otherwise in the tube, for its muscular walls are thin and fail to contract. Nature however does sometimes provide against this, as in case already referred to, where the fimbriated extremity was glued down to floor of the pelvis by organizing blood clot. This dammed the blood backwards into the tube and saved the patient from the alarming hæmorrhage which followed our very slight manipulations.

The seat of rupture will also markedly affect the course and symptoms. If the tube rupture on its peritoneal surface the hæmorrhage is apt to be excessive and fatal; if it ruptures on its extra-peritoneal side into the broad ligament the hæmorrhage will be limited and very apt to be often repeated, as in the case I saw with Dr. Sponagle.

The development of the ovule is subject to many vicissitudes and this powerfully influences the course and symptoms. The chorionic villi are not well nor freely developed outside of the uterine cavity. They are therefore easily separated from the tube walls, so that hæmorrhages are both imminent and frequent before rupture of the tube occurs. These hæmorrhages produce further separations so that abortions, partial and complete, are much more frequent than ruptures. The completely separated ovule shrinks and is often driven into the abdominal cavity, where nothing more is heard from it. The partially separated ovule on the other hand causes further trouble, as it does in the uterus, and demands operative interference to save the patient.

The ovule is liable to hæmorrhage inside as well as outside its chorionic membrane. The pressure of these internal hæmorrhages encroach upon the amnion pressing it against the foetus and killing it. The foetus thus destroyed is often disintegrated so that nothing of it can be found macroscopically. Ovules of this kind are known as carneous moles, which is well shown in the specimen presented. They

are often absorbed and give no further trouble, but this is by no means the only result. They may prolong hæmorrhage and demand intervention.

The compass of this paper will not permit of my taking up the results of development of the ovum after primary rupture. It is rare. Out of eight or ten cases, I have seen but one instance. Fœtal bones were passed per rectum, and the patient died. With our present knowledge such a thing should never happen in any ones practice, but unfortunately a primary rupture may not determine our being called and pregnancy may go on to secondary rupture before medical aid is sought.

Diagnosis.—It is far more important to detect the imminence of hæmorrhage than to diagnose its occurrence. There are only two cases recorded in Great Britain of diagnosis before rupture, mostly because patients consider themselves normally pregnant, and do not seek medical aid, partly, because of the difficulty of detecting a small enlargement in a Fallopian tube without an anæsthetic. If, however, according to Dr. Tucker Harrison, of New York, menstruation has been absent once or twice, if the uterus is soft, enlarged and elongated, if there are objective and subjective signs of pregnancy, if there be a soft elastic tumour in the tube with strong arterial development, if, according to Dr. Veit, there be felt transitory hardness of the tube, then look out for rupture and pelvic hæmorrhage. If now there be hæmorrhage from the vagina coming on suddenly with pain and faintness, either one of two things has happened, viz: vascular rupture outside the sac or tubal rupture into the peritoneum. If the former the patient will rally after a few hours, if the latter the patient will generally die unless promptly operated on.

If the physician be still in doubt and wait, and there be found a soft illdefined fulness which from week to week becomes harder and more defined, if there be recrudescences of pain and temperature with illness, with or without bladder symptoms, then the diagnosis of pelvic hæmorrhage is confirmed and operative measures become imperative.

If, finally, soon after symptoms of rupture, there be found a well marked tense elastic tumour to one side and behind the uterus, pushing the uterus upwards and forwards towards the symphysis, then the diagnosis of extra-peritoneal hæmorrhage into the broad ligament may be accepted. Few conditions simulate rupture. Abortion can be excluded by the absence of free or alarming hæmorrhage, by the arterial quality of the blood, by the different character and location of the pains and by the absence of abdominal tenderness. The curette will clear up any doubt. I used it in two of my cases. In one of these the microscope revealed a well marked decidual membrane.

A retroflexed fundus with accompanying congestion and hæmorrhage can be excluded by the absence of a missed period and of sudden onset, the non-elastic feel of the fundus, and the cautious use of the sound.

Salpingitis, pelvic cellulitis and ovarian tumours by the history course and physical signs pecular to them.

Treatment. According to the books not every case of pelvic hæmorrhage requires operation. Many will recover if left alone. But some will be lost and many will have a tedious convalescence. It is safer therefore to operate in many if not in all cases as soon as the diagnosis of pelvic hæmorrhage is reasonably well established. I operated on all my cases but the first, and this is the only one I lost. Two or three of the other cases might have got well if left alone, but even in these, recovery after operation was prompt. They were saved from a tedious convalescence at least, and from complications which might after all prove fatal. There must be no hesitation about operating in hæmorrhages of an alarming character, no more than there should be about tying a bleeding vessel. Cases that rally from a moderately severe hæmorrhage, do well for a week or more, and then sustain a second hæmorrhage, should also be operated upon promptly. Cases in which the hæmorrhage is small but continuous, as evidenced by an increasing hæmatoma or hæmatocele and a lasting discharge from the vagina, also require operative measures. Lastly, of course all cases which go septic from infection of a stationary or decreasing hæmatoma or hæmatocele. The dreadful possibility of an ovule going on developing after rupture in the absence of operative measures should never be overlooked. The same rule might apply here as in appendicitis. Whenever you find it, operate, and this in spite of the fact that most cases will get well if left alone under expectant treatment. An appendix that has once inflamed is prone to inflame again. A tube that has once become pregnant may do so again, and the safest place for it is in the spirit bottle.

Choice of operation. This is important, and the question of whether the hæmorrhage is active or passive should guide us. I prefer the abdominal route in all active hæmorrhages. One has more room and can see what he is doing, and be master of the situation. I adopt the vaginal route in the passive conditions of some weeks standing such as hæmatomas of the broad ligament and hæmatoceles in the pelvis which press the vaginal septum well downwards. A hæmatocele may appear to recede under an anæsthetic, when the abdominal muscles are relaxed. In one case I desisted from a vaginal operation at the patient's home on this account, and sent her to the hospital for abdominal section. It was fortunate I did so, for the operation was difficult and attended by considerable hæmorrhage. The vaginal operation has proved fatal in some instances owing to hæmorrhage which could not be controlled before opening the abdomen. It would be wise therefore to have the patient prepared for such a contingency, when resorting to the vaginal route.

On the other hand I have twice opened the abdomen and on finding extensive hæmatomas in the broad ligaments, I resorted to the vaginal

route, in order to save the peritoneal cavity. In these cases, should hæmorrhage have occurred in clearing out the blood clot from below, no time would have been lost in controlling it from above.

A word in conclusion as to the history and literature of pelvic hæmorrhage. Its pathology remained for a long time shrouded in conjecture. To France belongs the honour of being the first to clear up the obscurity somewhat, by several valuable post-mortem reports. But, as in many things, others laboured and the British have entered into their labours. To Lawson Tait belongs the honour of first, in 1883, opening the abdomen and removing a ruptured tube. But to Parry, of Philadephia, in 1875, we are indebted for first recommending what Tait seven years later accomplished. Parry, though American, was of course a Briton, a round head let loose and clad in the flying garb of Uncle Jonathan, a cross between a rampant lion and a soaring eagle, both seeking whom they may devour.

Dr. Cullingworth, in his Bradshaw lecture in 1902 says :—"In the year 1879, Dr. John S. Parry, whose monograph on extrauterine pregnancy based upon the published record of 500 cases presents an admirable example of patient labour and careful investigation, wrote in burning words of the helpless attitude of the profession at that time when confronted by this terribly fatal form of hæmorrhage. He spoke of it as an anomaly which had no parallel in the whole history of human injuries and made a powerful appeal to his professional brethren to adopt the only resource for rescuing a woman under these unfortunate circumstances."

On page 219 Parry thus writes :— "There is nothing unreasonable in the recommendation which is thus made, and there is no reason to believe that it will be impossible to arrest the hæmorrhage after the abdominal cavity is opened. It will not be arrested unless this or some other equally bold measure is resorted to. It appears to be simply criminal to sit idly by and see a woman die from rupture of an extrautine foetal cyst, without attempting to save her. The question is not will the patient die after the operation. It is will she live if abandoned to nature. This was answered in sobs and sorrows of stricken households long ago. Are the dangers of opening the peritoneal cavity less than those of rupture? The history of abdominal surgery and that of the condition which is being discussed teach us that they are infinitely less."

Again quoting Dr. Cullingworth. "For some years this appeal was practically disregarded, but in 1881 a notable incident happened. A general practitioner in the Midlands, Dr. Hallwright, sent for Mr. Lawson Tait to see a patient with him who had arrived from London in a condition of serious illness diagnosed by Mr. Hallwright as probably hæmorrhage into the peritoneal cavity from a ruptured tubal pregnancy. With this diagnosis, Tait agreed.

The patient was blanched and collapsed and Mr. Hallwright made the bold suggestion that Tait should open the abdomen and remove the ruptured tube. "The suggestion," says Tait, "staggered me and I am ashamed to say I did not receive it favourably. I saw the patient again, and again I declined to act upon Mr. Hallwright's request. And a further hæmorrhage killed the patient. A post mortem revealed the perfect accuracy of the diagnosis and I now believe that had I operated the patient's life would have been saved." Eighteen months after this Mr. Tait, profiting by what he calls his terrible lesson, opened the peritoneal cavity for a case of this kind. He stopped the hæmorrhage and excised the tube with its cyst, but unfortunately lost his patient Notwithstanding this Mr. Tait continued to operate, and his success, as well as that of those who followed his example, abundantly justified the pressing recommendations of Dr. Parry.

So much for the later history of pelvic hæmorrhage. The earlier history is very well outlined in Dr. Thomas' work on Gynæcology. Dr. West, in a foot-note, is also valuable. The earliest monograph in English is that of Dr. Campbell, Edinburg, 1840. Then followed Dr. Parry's, Philadephia, 1876, and Mr. Tait's, 1888. The bibliography of the subject is very fully given in Dr. Williams Obstetrics, taking up four and half pages of the valuable work.

In conclusion I wish to say that medicine is a science of exceptions, and that these must be gathered as we travel on the road. I set out with the aim of giving the results of what I have seen and learned and as I have met with no exceptions to the ordinary symptoms of pelvic hæmorrhage incident to ectopic gestation I have therefore said nothing about them. All my cases presented similar clinical outlines and I have endeavoured to group these so as to form one picture instead of wearying you with single tracings of all my cases. I am content if I have made the physiognomy of the general run of cases more clearly discernible.

# ADDRESS IN MEDICINE.—CANADIAN MEDICAL ASSOCIATION.*

By R. E. McKechnie, M. D., Vancouver, B. C.

*Mr. Chairman and Gentlemen,*—In asking a member of the profession residing in the far West to deliver the address in medicine, I feel that a compliment has been paid, not so much to myself, as to the West. To demand that we, living so far away from the centres of learning, from the great teaching institutions of the East, should nevertheless be expected to keep ourselves abreast of the times and in touch with the latest discoveries, is surely expecting a great deal; and then to expect that one, living under such barren influences, should be able to give you an address equal to this occasion, containing some food for thought and pointing out the pathway of duty and practice, is to look still further for a miraculous manifestation. But the genius of the West is ever equal to all occasions. It has grown accustomed to the knowledge that the best wheat in the world grows in our North-West; that our forests can supply the hugest sticks of timber known to commerce; that our fisheries can supply the world with illimitable quantities of salmon, halibut and other delicacies; always the best, the hugest and the illimitable, ever the superlative. So it is not strange that a strong egotism has developed out here, sufficient even to accept this task, and hoping but with misgivings, that its self-sufficiency may not suffer in the attempt. Personally, I feel that a great honor has been conferred on me, and I most sincerely thank the Association for its kindness, and trust that its confidence may not have been misplaced.

As to-day we seek to adapt treatment according to the cause of disease, so, looking back to the remotest ages, we find the human instinct groping along the same pathway. But in the early ages of the race science was unknown, and miracle was seen in every unexplainable phenomenon. Hence disease was attributable to the wrath of a good being or the malace of an evil one, and treated accordingly. Among the ruder tribes the Medicine-man has ever held sway; but even in higher civilization we find that in Egypt the priests of Osiris and Isis claimed powers over disease; in Assyria, the priests of Gibil; in Greece, the priests of Æsculapius; in Judea, the priests of Jehovah. While these have ceased to exist with the decay of their respective religious systems, the ruder primitive tribes have persisted. They are found among the aboriginal tribes of Africa to-

*Read at meeting Canadian Medical Association, Vancouver, B. C. August, 1904.

day, as also on this side of the Atlantic. Parkman, in discussing the customs of the Hurons, says: "A great knowledge of simples for the cure of disease is popularly ascribed to the Indian. Here, however, as elsewhere, his knowledge is in fact scanty. He rarely reasons from cause to effect, or from effect to cause. Disease, in his belief, is the result of sorcery, the agency of spirits or supernatural influences, undefined and indefinable. The Indian doctor was a conjurer, and his remedies were to the last degree pre-posterous, ridiculous or revolting."

Among the Coast Indians in British Columbia the practice is still kept up, and it may interest you to hear me relate what I saw not forty miles from here only three years ago. In the Indian villages are to be found huge barnlike structures called rancheries, each consisting of one immense room and capable of accommodating twenty or thirty families. Living close to nature, the floor, of course, is mother earth. Rough stalls, arranged along the walls, separated by screens of rush matting and open toward the centre, form the none too private retreats of the individual families. Each lights its own fire on the earthen floor opposite, whereon their rude cooking is done. The smoke escapes through the shingles, as there is no chimney, and in the absence of windows the light comes in through the cracks in the wooden walls. I went down one evening to such a place to see a sick Indian woman. It was dusk, and the waves of the sea were lapping the beach close at hand, while dusky children flitted by in the twilight, engrossed in some pastime. On entering the only door in the rancherie, I found it in utter darkness, excepting for a small fire burning at the extreme end of the building. Here was presented a study in light and shade, to have suited a Rembrandt. Around the fire was arranged a circle of Indian women (it is always the women who are closest to the mysteries of nature), while at one side was the patient, too weak to sit up, but supported by a couple of sympathizers. Facing her was the Indian Medicine-man, trying to cure her disorder by directing his energies to overcome the supposed cause of her disease. My diagnosis was tubercular pleurisy with effusion, but my Indian confrere had diagnosed possession by an evil spirit, and as he was in charge of the case, I could only look on. Each woman, with a stick in either hand, was beating on a piece of wood before her, making as much noise as possible, and adding blood-curdling expletives to the incantations of the Medicine-man, in a vain endeavor to drive out, to scare out, the possessing spirit. But unfortunately this kind comes not forth by such rude wooing. And so, from the gray dawn of time, down to what we imagine is the mid-day splendor of to-day, such forms of practice have persisted through all the ages.

But let us not imagine the air clear yet; the fog is only getting thinner. In other times the sun has attempted to shine through. Five hundred years before Christ, Hippocrates broke away from the old traditions of healing, the supernatural methods, and laid the foundations of medical science on experience, observation and reasoning. Later his teaching influenced the school of Alexandria, where positive knowledge was developed by the adoption of anatomic studies; and centuries later, under Moslem patronage, the medical sciences reached their highest development in the Middle Ages. But Europe was less fortunate under Christian influences. There was a return to the belief in the supernatural origin of disease, and to the practice of supernatural methods to combat it. Retrogression prevailed over progression. Still believing in demoniacal possession, the various phases of exorcism were practised, even combined with such practical methods as the following: "To disgust the demon with the body he was tormenting, the patient was made to swallow or to apply to himself unspeakable ordures, with such medicines as the livers of toads, the blood of frogs and rats, fibres of the hangman's rope, and ointment made from the body of the gibbeted criminals." For myself I would prefer the simpler methods of the British Columbia Medicine-man. Cures effected by relics, by pilgrimages and sacred observances obscured the horizon, while even the Divine Right of Kings gave the world the blessings of the Royal touch for King's Evil. All these practices were injurious to the development of medical science, for "why should men seek to build up scientific medicine and surgery when relics, pilgrimages and sacred observances, according to an overwhelming mass of concurrent testimony, has cured hosts of sick folk in all parts of Europe?" But finally the tide turns. The discoveries of Galileo, Kepler and Newton had their reflex on the sister science of medicine, and investigators made bold to pry into the secrets of life and learn her vital processes, to seek the true causes of disease and endeavor to find the cure. Relapses have occured. As fanatics opposed the introduction of the fanning-mill because it infringed on the divine prerogative, which furnished the wind to winnow the wheat from the chaff, similarly, opposition arose to the introduction of inoculation, vaccination and the use of anæsthetics. And as supernatural agencies were invoked to cure diseases supposed to be of supernatural origin, so to-day we have the various sects of faith-healers, magnetic healers and what not.

But, as Carlyle says, "Only what is true will persist. Out of the merciless fire of modern criticism truth, like asbestos, will come forth purified; but vain theories, gaseous, will be dissipated among the waste winds forever."

But where do we stand today? Have the fogs all lifted and do we now see clearly? Unfortunately not. Investigators today are not numbered by tens but by hundreds, pursuing many diverse threads of thought, and giving to the world their conclusions, fully formed or immature, probable or fantastic, relevant or irrelevant.

The search for the causes of disease still continues as actively as ever, but disappointments are far more numerous than successes. Concerning sarcomata, Stimson, in this month's *Annals of Surgery*, says: "We are absolutely in the dark as to etiology, and no further advanced in prognosis and treatment than were our colleagues a quarter of a century ago."

Dr. Snow, Chief of the London Cancer Research Committee, has come to almost identical conclusions regarding carcinoma. As regards these two classes of disease, we are, therefore, forced to be content, at present, with increased ability to diagnose them, and have to thank the surgeon largely for the groundwork of this advance.

In 1882 Koch proved tuberculosis to be due to a specific bacillus, and in 1890 startled the world with the announcement of a cure. We all remember the reaction, the tremendous disappointment, felt not only by the laity, but even more keenly by ourselves, when slowly, unwillingly, we were forced to admit that our expectations were not realized. Early in 1903, Behring delivered a lecture before the Vienna Medical Society, detailing his experiments on animals with his own special serum, and speaking very hopefully as to the future. Perhaps he, who with Roux, discovered in diphtheritic antitoxin the greatest remedial agent of recent times, will unravel the puzzle.

More recently, Marmorek, of Paris, has staked his great reputation by giving to the world the results of his labors in a new serum, and we can only trust that time will prove that it possesses some definite value. Later still, that our professionally agnostic brethren may not starve for want of food, an Italian professor has enunciated that Koch's tubercle bacillus is not the cause of phthisis, but rather an uncouth octopoid micro-organism of his own finding. Well may the general practitioner raise his hands in despair and wonder what he can believe.

But experience has shown that in tuberculosis, as in other things, prevention is better and surer than cure. Statistics are piling up year by year, adding proof where now none is needed, that, recognizing tuberculosis as an infectious disease and treating it accordingly, a definite gain can be recorded. Education of the public has already advanced so far that more positive steps should be enforced. Compulsory notification, as in other infectious diseases, proper disposal of infected excreta, disinfection of infected dwellings, etc., should be rigidly carried out, and the same positive results would be attained throughout the country at large as already obtain in the few places far advanced enough to follow this self-evident line of action.

A resolution should be passed by the present meeting, urging the various provincial governments to introduce the necessary legislation, and I venture to affirm that, coming from so influential a body of scientists, the suggestion would be adopted. And, if adopted, as I have already said, the educated sentiment of the public would not obstruct, but rather would uphold the action of the authorities. Perhaps this body has already taken such action, but until the various authorities have adopted the suggestions, I consider it the duty of this Association to yearly reiterate the advice. Then finally will begin an era of diminution, until, as some of our more optimistic brethren affirm, fifty years will see the extinction of the Great White Plague.

Councilman's pronouncement as to the causative agent of variola still remains unchallenged; while more recently Mallory, of Boston, has described a protozoan which he has named cyclaster scarlatinalis, and which he believes has a causal relation to scarlet fever. In the winter of 1902-3, Mosher, of the Kinderspital in Vienna, announced the discovery of an anti-scarlatinal serum prepared from a coccus constantly found in the throats of subjects of that disease. His statistics, covering several hundreds of cases, both mild and severe, were, as such statistics usually are, certainly favorable; but he failed to prove his coccus as the cause of the disease, and the consensus of opinion inclines to believe that the favorable results were due to the combatting of the influences of a mixed infection. The same favorable results can also be obtained by the use of antistreptoccic serum, which reagent, in other forms of infection, has not the wide use among the profession that its virtues demand.

To turn to another field, where surgery and medicine meet, we find that some definite progress has been made. Numerous operations on the stomach have shown that ulceration is more common there than formerly suspected. The physician of to-day must not expect to find all the classical symptoms, for we can have ulceration without pain as we also can have it without hæmorrhage. Brilliant results have been obtained in most inveterate cases, by operative methods, results such as medicine has not afforded. Under these circumstances we have the added responsibility of advising some of our patients to submit to the risks of an operation, a responsibility which will often tax our courage to the utmost, but which we, as true men, should not shirk when the occasion arises.

In diseases of the biliary tract, surgery has also disclosed many new features. The post-operative biliary fistula, in cases of obstruction of the common duct, affords a positive means of correctly estimating the quantity and qualities of the bile. The use of cholagogues has an established place in our practice, but now our faith is rudely shaken. Although the term cholagogue has been in use for more than two thousand years, and is apparently as firmly seated as

the everlasting hills, recent investigations have caused it to tremble, and it may eventually disappear as did many a mountain in some prehistoric cataclysm. Mayo Robson, in estimating the effects of certain so-called cholagogues, found that the old reliable calomel caused a diminution instead of an increase in the flow of bile. Euonymin gave the same result, while rhubarb and podophyllin, turpentine and benzoate of soda gave negative results. His conclusion is: "The supposed cholagogues investigated seem to rather diminish than increase the amount of bile excreted." Perhaps the most of us feel like saying as the fox to the grapes, "We did not think they were much good, anyway."

As regards cholelithiasis we have also learned a great deal, and have had to revise our views as to etiology, and must consider the typhoid bacillus and the bacillus coli the primal cause for the majority of the cases. The French school go so far as to affirm that, without infection at some stage of the disease, we will not have cholelithiasis. Legars says: "The infectious origin of biliary lithiasis is proved, for the following reasons: If we have shown that gall-stones do not depend on general and obscure humoral conditions, but on a local infectious process, the disorder becomes for the most part also a local matter, and as such accessible to direct local means. If the calculi are once formed, they increase and multiply, and we can still be sure that they are due to a single attack of lithogenous infection. At a given moment, microbian invasion of the gall-bladder took place, and these microbian invasions, of intestinal origin, depend on various causes and may occur in the course of different acute disorders: at any rate the calculous disorder comes from this primordial lithogenous cholecystitis Once more, it is a complaint of the gall-bladder and ducts, not of the bile, and lithogenous cholecystitis is comparable to many other localized infections, such as appendicitis, for instance. By removing the calculi, or the gall-bladder, recovery may be complete and final. Finally, we find infection not only at the origin of lithiasis, but also at all stages of the disorder; it is the leading factor of the various complications as well as of the prognosis of the complaint."

Deaver says: "It can be emphatically stated that gall-stones are always the result of precipitated salts and tissue debris, following in the wake of bacterial infection, mild or severe in degree. Furthermore, the complications of chronic gall-stone disease, adhesions, ulceration, fistulæ, liver and pancreatic disease, are also due to infection." He also says: "The treatment of chronic gall-stone disease, its complications and sequelæ, can only be surgical. Gall-stones are formed through the aid of infection, and therefore the disease is local and requires local treatment, that is, operation, and not solvents or cholagogues to relieve a condition resulting from faulty metabolism."

Therefore, the same application can be made here as was made in reference to gastric ulceration. We should realize the impotence of medicines. Solvents do not dissolve, and the old treatment was merely that of temporizing, with the hope that Dame Nature would aid our misguided efforts by expelling the offending bodies through the natural passages. Such expectancy is often dangerous Surgery holds out a positive cure in a large proportion of cases, but too many of us fear the responsibility of advising such radical treatment, and our patients suffer from our timidity.

Let us now return to a consideration of the work being done by our great army of investigators. In reviewing their work, not only that of the past year, but of recent years, we see labor multiplied, mountains heaped on mountains in the attempt to scale the heights of the unknown, until, considering the results attained, we might be forgiven for inquiring, "What avails so titanic a struggle?" The causes of disease are so intricate that they are reached only after ages of scientific labor. Yet a few successes have proved to be stars of the first magnitude, others but the smallest flint sparks to illuminate the truth, whilst many so-called discoveries have given no more light than when wax is struck on wax, idle theories, thoughts written on the brain, and now, let us hope, rubbed out for ever. Looking at the workers as constituting an army, one searches in vain for a controlling spirit, one which will concentrate the tremendous and apparently never-tiring energies of this mass of workers into a well-directed assault on some stronghold of the unknown. Modern investigators are, to quote a phrase of Carlyle's, "like a hapless servant gone masterless, unfit for self-guidance." To give an idea of the varied subjects being studied, let me quote the titles of a few of the papers published during the year in but one publication, *The Journal of Medical Research*: "On the Appearance and Significance of Certain Granules in the Erythrocytes of Man," "The Influence of Certain Bacteria in the Coagulation of the Blood," "The Relation of Specific Gravity and Osmotic Pressure to Hemolysis," "The Bacteriolytic Complement Content of Blood Serum," "The Agglutination of the Pneumococcus with Certain Normal and Immune Sera," "Cat's Blood: Differential Counts of the Leucocytes," "A Study of the Agglutinating Hemolytic and Endothelialitic Action of Blood Serum in Variola," and so on. I do not wish to speak slightingly of the labors which these titles of so diversified investigations portray, but I do affirm, that if the workers of some one strong school were under one sole control, their campaign planned against one enemy, and their work properly correlated, more progress would be made in a given time than by the independent, uncorrelated work of all the schools combined.

Such a view is perhaps too utopian. The world will "gang its ain gait," and our workers will continue to work as before.

Truths will gradually be unfolded and science will be developed in the medical field as in the other realms of science. As Marconi did not have to wade through all the drudgery of elaborating the data he needed, but utilized the work of others in perfecting his discovery; as Roentgen needed to win but a single step in advance of others in the race to gain the palm, so, too, can we confidently look forward to the appearance of a master from among our members, one who, building with the bricks made by others, will erect the edifice of truth containing the key which will unlock the secrets of nature and give us command over our most illusive foes. We all feel that that day is near at hand, and when it dawns we will join unselfishly, without a trace of jealousy, in crowning that master with the everlasting laurel.

In conclusion, Mr. Chairman and gentlemen, I thank you for the patience with which you have listened to this address, and wish you every success in your labours in the Section of Medicine.

# THE POSITION OF THE KIDNEY AFTER NEPHROPEXY.*

AUGUSTIN H. GOELET, M. D., Prof. of Gynæcology, New York School of Clinical Medicine, Gynæcological Surgeon to the Metropolitan Hospital for Women and Children, etc.

Restoration of the prolapsed kidney to its normal position, the author believes, is essential to restore to normal action the kidney already crippled in consequence of the displacement which interferes with its circulation and function. He does not share the belief of those who regard the abnormal mobility of the organ as the sole cause of the symptons, but rather its abnormally low position.

If downward displacement of the kidney causes inflammation of the organ, as has been shown,† because of interference with its circulation and function, it is not reasonable to believe that fixation in an abnormally low position will effect any change in the condition so far as the kidney is concerned.

The prolapsed position of the kidney seriously interferes with its circulation and function, and when fixation is made lower down than normal the same condition prevails, with this difference, that it is permanent, whereas before fixation the recumbent position of the subject permitted normal replacement with consequent relief for some part of every 24 hours, which is not possible after such fixation. An additional objection to fixation too low down, below the rib, is that compression of the kidney by the corset or clothing is permitted and it cannot escape as before. Such compression is a constant source of irritation. Hence fixation of the kidney lower than normal leaves both patient and kidney in worse position than before.

The author takes this occasion to repeat the position he has maintained throughout, viz., that splitting or peeling of the fibrous capsule of the kidney is both unnecessary and unwise, because just as firm attachment can be secured without such mutilation, and restoration of the kidney to its normal position will re-establish normal action, and the associated nephritis subsides, provided the operation is

* Abstract of a paper read at the second annual meeting of the American Urological Association, at Atlantic City, June 9th, 1904.

† Medical Record, December 20th, 1902.

resorted to early, before permanent structural changes have taken place. In other words, he believes that any case of nephritis due to or associated with prolapse of the kidney that is curable by splitting or peeling off the fibrous capsule, may likewise be cured by fixation alone without depriving the kidney of its fibrous capsule, if the organ is restored to its normal position.

The kidney suspended by its partially detached fibrous capsule by sutures securing it to the muscles exposed in the incision must necessarily cause attachment of the kidney too low down.

The author believes his method* of inserting the sutures and bringing them out and tying them on the surface at the upper angle of the incision is the best way of securing the kidney in its normal position. He reports 184 consecutive nephropexies by this method without mortality and without a failure to secure permanent fixation with subsequent relief of symptoms.

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* Journal of the American Medical Association, November 7th, 1903.

# IMMEDIATE TRACHELORRHAPHY.*

By F. H. Wetmore, M. D. Hampton, New Brunswick.

Ever since Emmet's method for repair of the lacerated cervix was first published, 35 years ago, much has been said and written on the subject. What cases or class of cases require an operation, and what do not; whether or not the pelvic lesion in a neurasthenic patient bears the relation of cause and effect to her many apparently reflex symptoms; and whether or not a cervical laceration is one of the exciting causes of malignant disease in this locality, are still considered debatable questions, and will not be discussed in this paper. But pathological conditions of the pelvic organs that call for treatment, operative or otherwise, such as chronic cervical catarrh, erosion and hypertrophy of the cervix, cellulitis, endometritis, subinvolution, have so constantly associated with them a laceration of the cervix, that one is forced to conclude that the laceration is a contributing cause to the morbid condition.

It has been only during the last 8 or 10 years that obstetricians in large numbers have endeavoured to prevent this train of morbid symptoms and conditions following a laceration by attempting primary union by suture. When we remember that nearly one third of parous women have a laceration of the cervix (52.8% Emmet) we will realize how important this subject is to the general practitioner as well as to the specialist in obstetrics.

The lacerations usually occur laterally, and vary in extent from a mere indentation of the external os, to a wide fissure extending several inches, to the vaginal fornix. These lacerations are found to be more extensive in forceps cases, tearing taking the place of stretching.

Some of the Advantages of Immediate Suture.—*It stops hæmorrhage.*—Rupture of the circular artery has frequently caused death. After the third stage of labor, with a contracted fundus and severe bleeding, the cervix should be examined. If the cervical laceration is found to be the source of the bleeding, one or more sutures will control it, and the resulting union is excellent.

*It prevents sepsis.*—Many authorities hold that immediate union tends to prevent the septic process from extending to the pelvic connective tissue and the peritoneum.

And lastly *it aids involution*, and saves the patient from the later dangers of a lacerated cervix.

*Read by title before the New Brunswick Medical Society, July, 1904.

Objections to the Operation.—Since choosing the subject of my paper, I have been informed that many of the best teachers have modified the immediate operation. They say that in city hospitals particularly, where sepsis is more frequent than in private practice, the immediate narrowing of the cervical canal by suture seems to increase the danger of sepsis. It prevents free drainage from the uterus, and, in case of sepsis, intra-uterine treatment is not so readily carried out. After the danger of sepsis is over and the uterus has retracted within the pelvis, about the 10th to 14th day, the cervix is examined, and if a rent of any extent remains, the edges are freshened and the cervix repaired. The results are said to be good. It will be difficult however to get private patients to consent to this secondary operation.

In forceps cases or where version has been performed, I would certainly advise immediate repair of the cervix while the patient is still under the anæsthetic ; that is in case the laceration is sufficiently marked.

Of course it is not necessary to suture the smaller lacerations —they heal during the puerperium without suture.

The Operation.—Only those who believe in rigid asepsis and antisepsis during the conduct of labor, of the external parts of the patient as well as of the hands of the accoucheur and of his instruments, should attempt the operation. A nurse and one assistant are necessary. In the absence of a legholder one assistant stands on either side, the nurse giving the anæsthetic as well. Place the patient in the dorsal position and use a perineal retractor, with two pairs of vullsellum forceps catch the lips of the cervix on either side of the rents, at the same time causing the assistant to make pressure on the fundus. The cervix can thus be brought well into view, and with a suitable needle and needle-holder,—I use Carsten's,—the operation becomes easy. The scissors may be required to remove lacerated tissues from the edges of the tear before the sutures are inserted. The sutures are inserted about one inch apart, beginning at the angle of the tear. Chromicized catgut sutures can be used and left in, or silkworm gut, which is removed in six or eight weeks.

## Correspondence.

### TUBERCULOSIS CONGRESS.

Mr. Editor, Sir,—

A few lines anent the annual meeting of the American International Congress on Tuberculosis, held at the World's Fair, St. Louis on Oct. 3rd, 4th and 5th, may not be unwelcome to the readers of the News. Having received an invitation from the Executive of the Congress to act as delegate for Nova Scotia, I accepted the honor. The convention was held in the Stadium of the Fair grounds. I may say that the congress is comprised not only of doctors of medicine, but of lawyers, legislators, and clergymen, that not only the medical world, but the world at large, may be interested in adopting means for preventing the spread of tuberculosis. The attendance was not as large and influential as I had anticipated, about five hundred being present during the six sessions. Every state in the union was represented either by delegates or letter; also Peru, Buenos Ayres, and Italy. One hundred and fifty papers were contributed, of which only one was read at the convention. It was found that the time of the congress was too limited for the reading of papers, and many of them were foreign to the subject in hand. The sessions were mostly occupied with addresses from Clarke Bell, Ll. D. and from Dr. Barride, the president, also from the delegates from each state, province, and country who confined their remarks to the medico-legal aspect, the promotion of sanitation, and the building of sanitaria for the treatment and segregation of consumptives. Professor Otto von Schroen, of the Royal University of Naples, contributed a paper of interest, a portion of which was translated and read to the convention. The professor explained that phthisis could not be cured. Apparently, a patient suffering from tuberculosis could live for years in a condition of apparent health, but, under conditions favorable to the development of the germ, it would again become active and destroy the lung tissue.

Professor Schroen argued that he had discovered a new kind of germ. This germ, combined with the tubercle bacillus, existed only in pulmonary phthisis and absent in all other forms of tuberculosis.

The segregation of the consumptive was one of the subjects of the meeting which elicited considerable discussion. Professor Hugh, of St. Louis, gave as his opinion that it was unwise and impolitic when making an early diagnosis of phthisis to confront the patient with the words "You have tuberculosis." He though the physician would better wait and tell him later if need be. This practice was objected to by a large majority of the convention. Some explained that while waiting they could not segregate or place the patient in as favorable condition for the successful treatment of the disease as modern methods demanded.

A little friction occurred during the last session when a doctor from Colorado Springs and one from Chicago declared that tuberculosis of the lung was non-communicable. These men had very few followers to support them. It was discovered, however, that the men who declared that tuberculosis of the lungs was non-infectious had some particular idea or medicine of their own to exploit.

One of the greatest features of the Congress was enlisting the services and co-operation of the International Engineering Congress, comprising some of the greatest authorities on sanitation on both continents, and of the National Fraternal Congress, numbering five and one-half millions of people. These forces will become allied against the germ of consumption. They will begin actively to interest the legislatures of the various states and foreign governments in the enaction of laws designed to prevent the spread of the disease which today is killing one-seventh of the population. Hereafter these two organizations will send their delegates to the International Congress on Tuberculosis and take part in its deliberations. With the wealth, influence and intelligence of this great triumvirate, the death rate from this disease will receive a material check.

My correspondence is already longer than I anticipated, and while there may be more I might say, regarding the Congress, I will not at present trespass further.

Yours truly,

G. E. DeWitt.

THE

# MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XVI. HALIFAX, N. S., OCTOBER, 1904 No. 10.

## Editorial.

### ADDRESS OF WELCOME.

On another page we publish an address of welcome from the Vancouver Maritime Provinces Association to the visitors from the maritime provinces attending the Canadian Medical Association. It is pleasant to know that those who have wandered nearly four thousand miles and made their homes have not forgotten the provinces that have given them birth. Many were the enquiries for those who were unable to sojourn to the West, while those who took that most enjoyable trip will remember with grateful recollections that hearty welcome from the maritime settlers of Vancouver. It is with pride we will always cherish the thought that though now widely separated we are yet inhabitants of one country.

## Editorial Notes.

A CANADIAN PRODUCTION.—Perhaps the most *taking* of the exhibits at the Canadian Medical Association was that of the Lacto-Globulin Company. Here was dispensed a product of Canadian enterprise by two trained nurses arrayed in suitable costumes, while a representative of the firm explained the many methods of using this easily assimilated food.

A ST. JOHN PRIZE-WINNER.—The last copy of *Clinical Excerpts* announces that Dr. G. G. Melvin, of St. John, was awarded the third prize in their recent competition. The subject was "The Indications

of Ergot Aside from its Obstetrical Uses," and we wish to congratulate Dr. Melvin for his success. This should be an impetus for other maritime physicians who are armed with sufficient energy and powers of observation.

A Progressive Firm.—It was our pleasure at visiting H. K. Wampole & Co's. Laboratory, at Toronto, last month, where we were enabled to view the most modern methods in pharmaceutical science Four years ago when this Canadian branch was opened, only six employees were engaged, while to-day no less than two hundred are busily occupied. Evidently, no mistake was made when Mr. Brick was appointed their Canadian Manager. Progressiveness on the firm's part, and faith in their products by the profession, has had much to do with such signs of activity.

The Canadian Pacific Railway.—The satisfactory way in which all details of the trip to the coast was carried out is in a great measure due to the efforts of Mr. C. B. Foster, Passenger Agent of the C. P. R. at St. John. Those on the special car from the maritime provinces feel deeply grateful for the attention shown them by all officials. They were fortunate in having a porter who was most attentive and painstaking, and will not soon forget their friend "Julius." All were ready to partake of three square meals each day, as the dining-car service was of a high order and amply satisfied the appetites of the eastern contingent.

A Birthday Presentation.—On the 20th of August before reaching Calgary, one of the representatives from Nova Scotia to the Canadian Medical Association was presented by the male members of the party with a silver cigarette case, and by the ladies with a peculiar shaped bottle containing a beverage familiarly known as "Mountain Dew." It was remarkable how quickly the recipient "took to the bottle" and thrived accordingly.

# Society Meetings.

## CANADIAN MEDICAL ASSOCIATION.

VANCOUVER, AUG. 23-26, '04.

### REPORT OF GENERAL SECRETARY OF THE THIRTY-SIXTH ANNUAL MEETING, HELD AT LONDON, ONT. AUG. 25TH TO 28TH, 1903.

The constitution and by-laws of the Canadian Medical Association require a report from the secretary of the last annual meeting. Inasmuch as my report last year was referred to as being notable for its "brevity," I thought to make this one a trifle more extensive; and in so doing, in order to impress upon you the splendid growth in membership and in attendance, at the annual meetings, will present some statistics.

The first decade after the organization of the Association in 1867, shows an average attendance of seventy-one. The second decade, from 1877 to 1887, shows an average attendance of 74.8; the third, 107.6; whilst the average attendance for the past seven years is 139.1.

At the annual meeting last year, 303 names were entered on the treasurer's register. That was the second largest meeting up to that time, being only exceeded in attendance by the meeting in Montreal the previous year, when 341 names were inscribed. The third largest meeting was in Toronto in 1899, when 242 were present.

At the last meeting 111 new members were admitted, and there were present 83 members of the profession who did not seek membership in our Association. This number is so large that I consider it important to call your attention to the fact that the mere signing of the treasurer's book and paying the annual fee, does not constitute membership in the Association, but what is required is nomination on the regular application for membership forms, approved by the executive committee, and election at a general session. By this process alone will your name be inscribed in the secretary's register of members.

It is very gratifying to record the large attendance at London last year, 303, and especially so in comparison with previous meetings in that city. It was the third time that a meeting had convened in London, the former occasions being 1880 and 1894. In 1880 the at-

tendance was 60; in 1894 it was 92—five times more than in 1880, and over three times more than in '94.

These figures emphasize, I think, the importance of Canada's national, medical organization, to the profession of this country, and certainly mark continued growth from year to year. I feel sanguine enough to prophecy that the attendance will never again go below the two hundred mark, if indeed it does not continue for the next five years to stay around three hundred or mount upwards.

Bearing this in mind, remembering the great good work it has done in the past, perhaps the most important to ourselves at all events being the organization of the Canadian Medical Protective Association, I cannot but feel that it is time that the Canadian Medical Asssociation be reorganized on the lines of the British Medical and Americen Medical Associations, so that we will be able to presenta stronger and a more united body in the prosecution of work which lies before us.

We have in Canada, Provincial, County, District and City Societies, which could readily and easily be made branches of the Canadian Medical Association. Our provinces all have Medical Councils, whose territorial representatives would no doubt undertake to organize their districts into branches. In this way, systematically organized, the Canadian Medical Association would be made a power in promoting legislation and in restricting the exploitation of a class denominated "quacks," who in this keen commercial age are very often sharp, shrewd business men, having behind them frequently strong financial force.

The attendance at our two last meetings coupled with the practice of economy has made for the Association a bank balance of some $550.00. This gives us a working capital. Surely it would be well for this Association to authorize its officers or a special committee, to undertake the publication of an annual volume of transactions. Towards financing this, I would suggest that the treasurer be authorized to render an account to each member on the secretary's register, on the 1st of Jannary of each year, for that year's membership fee. Surely no one would refuse to pay this fee annually, promptly, for a bound copy of the annual transactions of this association. At any rate it is time this matter was taken up with serious consideration.

This report and the suggestions embodied therein are respectfully submitted to you for your attention and consideration.

GEORGE ELLIOTT, *General Secretary.*

The following resolutions were passed at the Vancouver meeting:

### Resolution *re* Dominion Registration.

"The Dominion Medical Association regrets that the present mode of registration, so often and so emphatically condemned by the entire profession still continues in force. We regret the abscence of Dr. Roddick from this meeting and thank him for his great and persistent efforts to effect a change in the method of registration. We think the time has arrived when the profession should in every way take a more active interest and demand in a most emphatic manner the change. From no part of the Dominion can this united effort emanate than from this charming, fast-growing and resourceful city. We think a small committee should at once be formed in each province to confer with Dr. Roddick and to dvise any means which may be agreed on to effect this long deserved object. Let this associotion memoralize the Legislature of the Province of Quebec to pass the necessary legislation to legalize the Canada Medical Act, popularly known as the Roddick Bill, and that the secretary set forth on said memorial the many reasons which have been so strongly advanced at the meeting why it should be done, and further that an appeal be made by the Association to the College of Physicians and Surgeons of Quebec to use their all powerful influence to have the legislation passed, and that a copy of the resolution be forwarded to the various papers in the Province of Quebec for publication."

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### Resolution *re* Tuberculosis.

Moved by Dr. R. E. McKechnie, Vancouver, seconded by Dr. R. Eden Walker, New Westminister.

*Whereas*, Tuberculosis has been positively proved to be an infectious disease;

*Whereas*, The patient is the focus of infection and is capable of infecting, and does infect dwellings, clothing and private and public places generally;

*Whereas*, Statistics already available prove that compulsory notification of such cases, with educational oversight of the patient and those under exposure to the contagion, together with disinfection of infected materials and places has resulted in a diminution of the number of cases;

*Whereas*, The results of preventive medicine have been wonderful in other infectious diseases, and the same methods promise equally as great results in this disease;

*Whereas*, Such action, in the Dominion of Canada, lies with the various provincial governments;

*Therefore be it resolved*, That the various provincial authorities be and hereby are urged to at once take the necessary steps to bring

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Same formula as Lactopeptine Powder. Issued in this form for convenience of patient—who can carry his medicine in his pocket, and so be enabled to take it at regularly prescribed periods without trouble.

"Everything that the science of pharmacy can do for improvement of the manufacture of Pepsin, Pancreatine, and Diastase, has been quietly applied to these ferments as compounded in Lactopeptine."
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In the gastro-intestinal diseases of children, it also supplies both the food and the remedy, thereby fulfilling the same indications which exist in Typhoid Fever.

Each tablespoonful contains two minims of pure Beechwood Creosote and one minim of Guaiacol.

DOSE.—One to two tablespoonfuls from three to six times a day.

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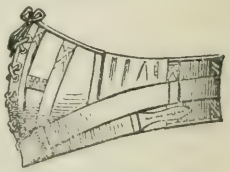

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these suggestions into effect, and that the secretary be requested to forward copies of this resolution to the secretaries of the various Provincial Boards of Health with the request that they lay them before the proper authorities.

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## Report of Committee on Public Health.

Vancouver, August 26th, 1904.

*To the President and Members of the Canadian Medical Association.*

Gentlemen,—Your committee in charge of the question of the establishment of a department of public health by the Dominion Government, have the honor to report that the matter has, to a certain extent, been in abeyance since our meeting at London last year. At that meeting you will recollect we reported certain interviews with the Prime Minister and the Minister of Agriculture at which we were led to understand that it was not feasible for the Government to give us any assurance that our wishes in the matter could be practically considered. The resolutions again passed at London pressing the subject on the attention of the Government as one closely associated with the country's welfare and best interests were duly forwarded to the Dominion authorities.

It was also pointed out to the Hon. the Minister of Agriculture by the convener of your committee that the medical profession of the Dominion as represented by the Canadian Medical Association were united in their desire to have such a department created and that they were only actuated in the matter by motives of patriotism, feeling assured that the administration of public health in matters pertaining to the Dominion Government would be greatly facilitated and rendered more useful and satisfactory if it emanated from a central department instead of having a series of branches having executive authority scattered through a number of departments of the Government.

Your committee are gratified to be able to report that there are evidences that, during the present recess, the matter will engage the attention of the Privy Council more seriously than it has hitherto done. Before legislation could be introduced certain questions involving much consideration will have to be settled, and we are given to understand that these preliminaries will be weighed before Parliament meets. While it is to a certain extent unsatisfactory to be obliged to report in such an indefinite way, yet we trust the Association will understand we have not been idle, but that in a matter of this kind we are in the hands of the good will of the Government,

and that it would be neither judicious nor delicate to compromise the present favorable opportunity by referring in detail to the reasons that have enabled us to hazard our present opinions.

Respectfully submitted,

R. W. POWELL,
*Convener of Special Committee.*

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RESOLUTION *re* PUBLIC HEALTH.

Moved by Dr. H. A. Lafleur, Montreal, seconded by Dr. O. M. Jones, Victoria.

*Resolved*, That the Canadian Medical Association regret that the Dominion Government have not yet seen their way clear to carrying out the suggestions contained in the several strong resolutions of this Association, passed during the past three years, on the question of the establishment of a department of public health under one of the existing ministers of the crown; that it be

*Further Resolved*, That this Association continue to press the wishes of the medical profession of the Dominion on this subject on the attention of the Government, inasmuch as we feel sure that the difficulties to be overcome in order to bring about such a desirable end are of small consequence to the public welfare compared to the beneficial results that will follow;

That the sub-committee in charge of this matter be reappointed at this meeting and requested to continue their efforts of the past three years;

That a copy of thie resolution be sent by the General Secretary to the Rt. Hon the Prime Minister to the Hon. the Minister of Agriculture and to the Hon. the Secretary of State.

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REPORT OF SPECIAL COMMITTEE—RESOLUTION *re* PATENT MEDICINE.

We beg to submit the following resolution for your approval, viz:

"It is a well-known and established fact that many of the most popular and saleable patent and proprietory medicines contain large quantities of alcohol and noxious drugs which are very injurious to the health of those making use of them, not only by their direct influence on health but by creating a depraved appetite for their continued use, which lead to the loss and disability of many valuable lives, and that the sale of these medicines is largely due to the manner in which they are advertised, their vendors making exaggerated and misleading statements through the general press, literature, posters and pamphlets as to their healing virtues and life saving qualities, thereby inducing sufferers from disease to purchase them to their very great injury, morally, mentally, and physically. The great and

growing increase in the consumption of these drugs is daily impressed on our profession by our observations of the injurious effects which are produced by them on a large and daily growing number of our population, and we feel that some urgent and effectual means ought to be adopted by these who are responsible for the health and welfare of the people that will control and restrict the sale of these most injurious and pernicious preparations.

And this Association, composed of the leading medical men from one end of the Dominion to the other, feels that the time has arrived when this great and growing evil to the public health must be suppressed; and this Association would strongly urge the Federal Government, through the department having the control and jurisdiction over matters of this nature, to take immediate steps to thoroughly investigate the nature and contents of these preparations and to suppress the pernicious and misleading form of literature and advertising by which this sale is so largely brought about, and adopt such general and effectual measures in connection with this matter as will insure the safety of the public health, and that a copy of this resolution be forwarded to the department of the government having control of such matters."

C. J. Fagan,
*Chairman Special Committee.*

Victoria, B. C.

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## A WELCOME TO THE MARITIME PROVINCES' MEMBERS OF THE CANADIAN MEDICAL ASSOCIATION.

The members of the Vancouver Maritime Provinces' Association extended a hearty greeting to the members of the Canadian Medical Association from the Maritime Provinces on the 25th August.

The affair took the form of a reception and welcome to the visiting doctors from the eastern provinces. Nearly two hundred members of the local association assembled in the smaller O'Brien Hall at noon and awaited the adjournment of the convention upstairs. Many of the ladies of the party were present. Each of the visiting doctors was presented with a pretty boutonniere, and a short time was spent in renewing old acquaintanceships.

### Address of Welcome.

Mr. John Johnstone, president of the local Maritime Provinces Association, read the following address:

*To the Maritime Provinces' Members of the Canadian Medical Association:*

"The Maritime Provinces' Association of Vancouver desires to extend to you a very hearty welcome to the Pacific coast and especially to the Lions' Gateway, our fair city of Vancouver.

"Our Association, now numbering over one thousand, resident in or near Vancouver, was formed for the purpose of bringing together natives of Nova Scotia, New Brunswick and Prince Edward Island in friendly and social intercourse, and of keeping in mind the varied and romantic history of the provinces by the sea, and the many distinguished men whose memories should never be allowed to fade.

"We regret that your stay in Vancouver is so limited, and that your time is too fully occupied to permit us to meet with you publicly. Our members would gladly embrace the opportunity to mingle with you and renew old acquaintances.

"We can assure you that we have not forgotten the homes of our childhood, whether these were on the rugged shores of Nova Scotia, or in its beautiful valleys; or by the peaceful Cape Breton Lakes; in the Garden of the Gulf, the fruitful island of Prince Edward, or in the forest-clad New Brunswick, with her wealth of beautiful lakes and glistening streams.

"Your visit brings these old scenes back to us and mitigates, to some extent, the three thousand miles intervening between us and 'home.'

"We trust you will carry away with you pleasant memories of your visit among us, and of this great province in which you are sojourning, which is so vast in area, so rich in resources and endowed so bountifully in scenery and climate.

"Here in Vancouver the grass remains green all winter, roses and other flowers bloom in the gardens in January and February, and the balmy breezes of the Pacific breathe perpetual summer.

"With renewed expression of our interest in your visit, and trusting that British Columbia will appeal to you in all its varied beauty, we ask you to convey our salutations to old friends at 'home,' and assure them that while loyal to the land of our adoption, our pulse yet beats true to the Maritime Provinces, and that we ever follow with warm interest their continued prosperity and development.

"Signed on behalf of the Maritime Provinces' Association of Vancouver, this 25th day of August, A. D. 1904.

"EDWIN S. W. PENTREATH,
Archdeacon of Columbia,
"*Honorary President,*
"JOHN JOHNSTONE,
"*President,*
"T. B. CROSBY,
"*Honorary Secretary.*"

THE REPLY.

After the applause which followed the reading of the address had subsided, Dr. James Ross, of Halifax, read the following reply on behalf of the visiting doctors from the Maritime Provinces:

*To the Maritime Provinces' Association of Vancouver.*

"The Maritime Provinces members of the Canadian Medical Association are deeply grateful to you for the hearty welcome and words of cheer extended to us.

"That such an Association as yours exists, with its large number of members, and showing storng evidence of a healthy growth, pictures that spirit of true fellowship that should fill the hearts of all those who have not forgotten their nativity.

"Since we arrived in your city we have been received with the greatest hospitality, and particularly from those whose 'homes' are so intimately associated with our own in the Far East.

"We will carry away glad memories of our visit, and particularly the knowledge that your hearts will ever beat true at fond memories of Home, Sweet Home.

Dr. J. A. Black of Windsor, N. S., also made a short reply to the address. He said that no man could make the trip across the continent and witness the evident progress and prosperity of the Dominion without feeling proud of this Canada of ours. On behalf of the visitors, he expressed himself as delighted with their reception, and also glad to see such a prosperous organization of former residents of the Maritime Provinces. Passing on to discuss Canadian loyalty and affairs generally, he said he thought the time was coming when Canada would take a more active part in directing her own affairs of state, and not leave such matters to men over whose appointment Canadians had no control. Dr. Black's remarks were loudly applauded.

After a short time spent in pleasant social intercourse, the gathering dispersed, as the visitors were pressed for time.

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## N. S. BRANCH BRITISH MEDICAL ASSOCIATION.

The annual meeting of the Nova Scotia Branch of the British Medical Association was held in the council chamber, City Hall, on Oct. 5th, Dr. F. W. Goodwin, president, in the chair.

The election of officers resulted as follows:

President, Dr. C. D. Murray; Vice-President, Dr. W. H. Hattie; Treasurer, Dr. G. M. Campbell; Secretary, Dr. E. D. Farrell.

Council—Drs. Goodwin, Hattie, Hare, Mader, G. M. Campbell, Mathers and Ross.

## Personals.

**Dr. E. Ross Faulkner,** of Mahone, is leaving this month for London, to take up post-graduate work.

**Dr. L. E. Borden** has just returned on the steamer "Neptune" on which boat he was engaged as medical officer for the past fourteen months. The "Neptune" was employed by the Dominion Government exploring in Hudson Bay, and had a most eventful trip. Dr. Borden is leaving for London and will accompany Dr. Faulkner to London on the steamer "Tunisian."

**Dr. H. P. Gouthro,** formerly of North Sydney, and now physician to the Timber Estates Company at Ganbo, Newfoundland, was married to Miss Monica MacPherson, of North Sydney, on the 6th inst.

The governors of the New York Skin and Cancer Hospital, announce that **Dr. L. Duncan Bulkley** will give a sixth series of clinical lectures on Diseases of the Skin, in the out-patient hall of the hospital, on Wednesday afternoons, commencing November 2nd, 1904, at 4 15 o'clock. The course will be free to the medical profession.

**Drs. M. Chisholm** of this city, and **N. F. Cunningham** of Dartmouth, have just return from a short trip to the hospitals of Boston.

**Dr. L. J. O'Shaughnessy** has recovered from an injury to the knee, which confined him to the house for a week.

**Dr. T. Trenaman** is able to attend to his professional duties, after a few days' illness.

The profession throughout the province sympathize deeply with **Dr. W. G. Putnam,** of Yarmouth, in the death of his father, Alfred Putnam, ex-M. P.

**Dr. W. A. Christie** of St. John, was elected exalted ruler, and **Dr. G. A. B. Addy,** chaplain, to St. John Lodge, No. 7 of the

Canadian Elks, which was organized on September 14th. We are not aware of the duties appertaining to these high offices, but we feel certain that Drs. Christie and Addy are eminently capable of filling any chair in sight.

## Book Reviews.

**The Doctor's Recreation Series**—Volume I. Arranged by PORTER DAVIS, M. D. The Saalfield Publishing Co., Chicago, Akron, New York. The first volume of this series which is entitled "The Doctor's Leisure Hour," comprises some 350 pages and is intended to cheer up the doctor in his idle moments. Some of the stories are rather good and entertaining' but unfortunately there are many which cannot appeal to the medical reader, or in any way brighten up his drooping spirits. The lay mind would better appreciate the funny side at least, and we will therefore deposit our copy where patients can peruse its pages. The second volume has been highly praised by some journals, and evidently appeals more to the professional mind than the first.

## Therapeutic Notes.

COMMENT ON ANTIKAMNIA & HEROIN.—Under the head of "THERAPEUTICS," the *Medical Examiner* contains the following by Walter M. Fleming, A. M., M. D.* regarding this valuable combination: "Its effect on the respiratory organs is not at all depressing, but primarily it is stimulating, which is promptly followed by a quietude which is invigorating and bracing, instead of depressing and followed by lassitude. It is not inclined to affect the bowels by producing constipation, which is one of the prominent effects of an opiate, and it is without the unpleasant sequels which characterize the use of morphine. It neither stupefies nor depresses the patient, but yields all the mild anodyne results without any of the toxic or objectionable phases.

When there is a persistent cough, a constant "hacking," a "tickling" or irritable membrane, accompanied with dyspnœa and a tenacious mucus, the treatment indicated, has no superior. In my experience I found one "Antikamnia & Heroin Tablet" every two or three hours, for an adult, to be the most desirable average dose. For night-coughs, superficial or deep-

*Qualified Examiner in Nervous and Mental Diseases for Supreme Court, New York City.

seated, one tablet on retiring, if allowed to dissolve in the mouth will relieve promptly, and insure a good night's rest. In short, it will be found futile to delve for a more prompt and efficient remedy than "Antikamnia & Heroin Tablets" in all bronchial complications with laryngeal irritation, dyspnœa, asthma, winter cough and general irritability of the thoracic viscera."

Sir William Roberts on Digestion.—Sir William Roberts, of London, the great authority on digestion, says : "The digestive change undergone by fatty matter in the small intestines consists mainly in its reduction into a state of emulsion or division into infinitely minute particles. In addition to this purely physical change a small portion undergoes a chemical change whereby the glycerine and fatty acids are dissociated. The main or principal change is undoubtedly an emulsifying process, and nearly all the fat taken up by the lacteals is simply in a state of emulsion.

This eminent authority is confirmed in the foregoing view by various experiments by which it has been ascertained that fat foods pass from the lacteals into the circulation by way of the thoracic duct in the form of an emulsion.

Emulsified cod liver oil as contained in Scott's Emulsion appears in a form so closely resembling the product of natural digestion—as it occurs within the body—that it may well be administered as an artificially digested fat food of the very highest type. In combination with the other ingredients mentioned—glycerine being an emollient of inestimable value—Scott's Emulsion offers to the physician a valuable, exquisite and rare accession to his prescription list.

Sanmetto in Atonic Conditions of the Genito-Urinary Organs Resulting from Chronic Urethritis.—"I have used Sanmetto quite extensively as a genito-urinary tonic in chronic atonic conditions of the genito-urinary organs, resulting from chronic specific urethritis, and have met with most excellent results."

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"There is purpose in pain."—*Lytton.*

Pain is nature's warning of some pathologic condition and is a diagnostic point of no small importance, especially in diseases of women. **Reflex Pain** in the Thigh, Lumbar or Occipital regions are many times signals of Uterine or Ovarian disturbances and are heeded by the careful practitioner.

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## HAYDEN'S VIBURNUM COMPOUND

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The therapeutic efficacy of Haydnen's Viburnum Compound and the favor wirh which it is received by the medical profession has induced unscrupulous manufacturers to try to imitate it, so be sure to prescribe the genuine H. V. C.

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Hayden's Uric Solvent Indicated in Rheumatic and Gouty Manifestations.

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**NO PLASTER CAST NEEDED.**

A Positive Relief and Cure for FLAT-FOOT,

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The introduction of the improved *Instep Arch Supporter* has caused a revolution in the treatment of *Flat-foot*, obviating as it does the necessity of *taking a plaster cast of the deformed foot.*

The principal orthopedic surgeons and hospitals of England and the United States are using and endorsing these Supporters as superior to all others, owing to the vast improvement of this scientifically constructed appliance over the *heavy, rigid, metalic plates* formerly used.

These Supporters are highly recommended by physicians for children who often suffer from *flat-foot*, and are treated for weak ankles when such is not the case, but in reality they are suffering from *Flat-foot.*

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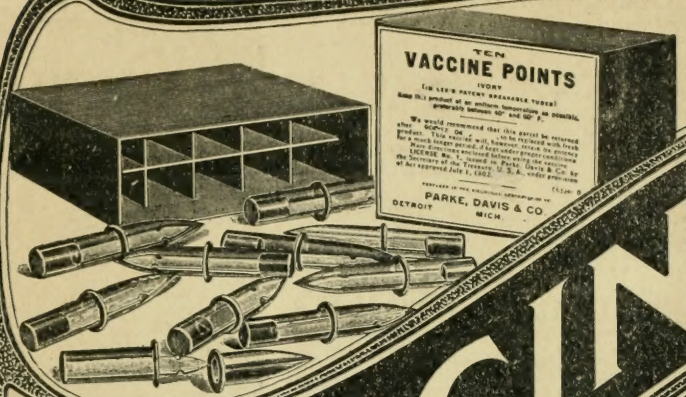


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*Capillary Glass Tubes*, hermetically sealed, boxes of 10 and 3. *Points*, each in a Lee's sealed breakable glass case, boxes of 10.

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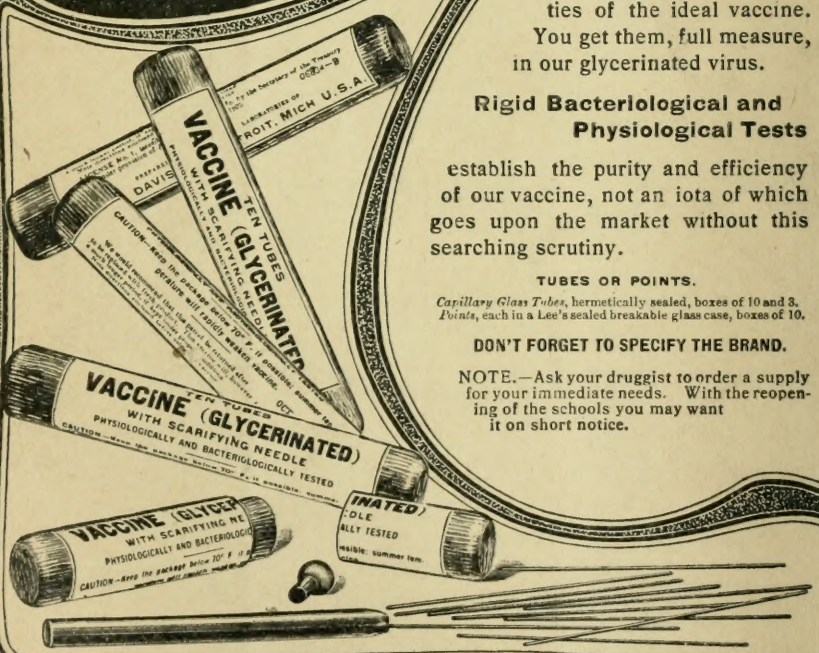


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